

ATTACHMENT 2

Sample CMS 1500 Claim Form: Transportation, Set-up, and X-ray Services When Two Medicaid Recipients Were Served

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																															
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> </div> </div> <div> <div style="display: flex; align-items: center;"> <div> 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890 </div> <div> PICA <input type="checkbox"/> </div> </div> </div> </div>																																																																																																																																																																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																									
5. PATIENT'S ADDRESS (No., Street) 609 Willow St				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																									
CITY Anytown		STATE WI		CITY		STATE																																																																																																																																																																																																																									
ZIP CODE 55555		TELEPHONE (Include Area Code) (xxx) xxx-xxxx		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()																																																																																																																																																																																																																									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER M-7																																																																																																																																																																																																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																									
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																									
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																																																																																																																																																									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																																										
14. DATE OF CURRENT: MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I. M. Referring			17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																									
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			\$ CHARGES																																																																																																																																																																																																																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V72.5					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																										
2. _____					23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																										
3. _____					4. _____																																																																																																																																																																																																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPSDT Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>05</td><td>01</td><td>04</td><td></td><td></td><td>31</td><td></td><td></td><td>R0075</td><td>UN</td><td>1</td><td></td><td>XXX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>05</td><td>01</td><td>04</td><td></td><td></td><td>31</td><td></td><td></td><td>Q0092</td><td></td><td>1</td><td></td><td>XXX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>05</td><td>01</td><td>04</td><td></td><td></td><td>31</td><td></td><td></td><td>72010</td><td>TC</td><td>1</td><td></td><td>XXX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE		05	01	04			31			R0075	UN	1		XXX	XX	1.0										05	01	04			31			Q0092		1		XXX	XX	1.0										05	01	04			31			72010	TC	1		XXX	XX	1.0																																																																																																									
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25. FEDERAL TAX I.D. NUMBER			SSN EIN			26. PATIENT'S ACCOUNT NO. 1234JED			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ XXX XX			29. AMOUNT PAID \$ XX XX			30. BALANCE DUE \$ XX XX																																																																																																																																																																																																													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>J.M. Authorized</i> MM/DD/YY						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 12341234						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Physician 1 W. Williams Anytown, WI 55555 87654321																																																																																																																																																																																																																			
SIGNED _____						DATE _____						PIN# _____ GRP# _____																																																																																																																																																																																																																			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)